Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 53 Coordination of Benefits

Authority: Insurance Article, §§2-109(a)(1) and 15-104; Health-General, §19-713.1, Annotated Code of Maryland

.01 Purpose and Scope.

A. The purpose of this chapter is to:

(1) Establish a uniform order of benefit determination under which plans pay claims;

(2) Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this chapter, do not have to pay benefits first; and

(3) Provide greater efficiency in the processing of claims when an individual is covered under more than one plan.

B. This chapter does not require carriers to use a coordination of benefits provision in a plan, but if a carrier includes in a plan any provision for the reduction of benefits payable because of other insurance, the provision for the reduction of benefits shall be consistent with the requirements of this chapter.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) Allowable expense.

(a) "Allowable expense" means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the individual.

(b) "Allowable expense" does not include:

(i) If a plan is advised by a covered individual that all plans covering the individual are high-deductible health plans and the individual intends to contribute to a health savings account established in accordance with §223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible, except for any health care expense incurred that may not be subject to the deductible as described in § 223(c)(2)(C) of the Internal Revenue Code of 1986;

(ii) An expense or a portion of an expense that is not covered by any of the plans;

(iii) An expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered individual;

(iv) If an individual is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, unless one of the plans provides coverage for private hospital room expenses;

(v) If an individual is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit; and

(vi) If an individual is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

(2) "Birthday" means the month and day of an individual's birth in a calendar year and does not include the year in which the individual is born.

(3) "Carrier" means:

(a) An insurer;

(b) A nonprofit health service plan;

(c) A health maintenance organization; or

(d) A dental plan organization.

(4) Claim.

(a) "Claim" means a request that benefits of a plan be provided or paid.

(b) "Claim" includes benefits that are in the form of:

(i) Services, including supplies:

(ii) Payment for all or a portion of the expenses incurred;

(iii) A combination of §B(4)(b)(i) and (ii) of this regulation; or

(iv) An indemnification.

(5) "Closed panel plan" means a plan that provides health benefits to covered individuals primarily in the form of services through a panel of providers that:

(a) Have contracted with or are employed by the plan; and

(b) Excludes benefits for services provided by non-panel providers, except for the following:

(i) For a health maintenance organization (HMO) contract, covered services as described at §19-701(d) of the Health – General Article

(ii) For a plan offered in accordance with §14-205.1 of the Insurance Article that conditions payment of benefits on the use of preferred providers (also referred to as an "exclusive provider organization" or "EPO", covered services as described at §§14-205.1(a)(1)-(3) of the Insurance Article

(iii) For a dental plan organization (DPO), covered services in the event of an emergency or an authorized referral by a member of the provider panel.

(c) "Closed panel plan" includes:

(i) A HMO plan offered in accordance with Title 19, Subtitle 7 of the Health – General Article

(ii) A preferred provider (EPO) plan offered in accordance with §14-205.1 of the Insurance Article

(iii) A DPO plan offered in accordance with Title 14, Subtitle 4 of the Insurance Article

(6) "Complying plan" means a plan that has coordination of benefit determination rules that comply with this chapter.

(7) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

(8) "Coordination of benefits" or "COB" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(9) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(10) Group-type contract.

(a) "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

(b) "Group-type contract" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured or member.

(11) "High-deductible health plan" has the meaning given the term under §223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(12) Hospital indemnity benefits.

(a) "Hospital indemnity benefits" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" does not include reimbursement-type benefits even if they are designed or administered to give the covered individual the right to elect indemnity-type benefits at the time of claim.

(13) "Intensive care policy" means a health insurance policy that:

(a) Is individually underwritten;

(b) Is guaranteed renewable;

(c) provides benefits only for treatment received in the specifically designated facility of a hospital that provides the highest level of care and is restricted to patients who are physically and critically ill or injured; and

(d) does not provide benefits on an expense-incurred basis

(14) "Non-complying plan" means a plan that:

(a) Is excess to other plans;

(b) Is always secondary to other plans; or

(c) Uses order of benefit determination rules that are inconsistent with those contained in this chapter.

(15) Plan.

(a) "Plan" means a form of coverage with which coordination is allowed.

(b) "Plan" includes:

(i) Group and nongroup insurance contracts and subscriber contracts;

(ii) Uninsured arrangements of group or group-type coverage;

(iii) Group and nongroup coverage through closed panel plans;

(iv) Group-type contracts;

(v) The medical care components of long-term care contracts, such as skilled nursing care;

(vi) Medicare or other governmental benefits, as permitted by law, except as provided in §B(15)(c)(ix) of this regulation; and

(vii) Group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(c) "Plan" does not include:

(i) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(ii) Accident only coverage;

(iii) A specified disease policy;

(iv) Specified accident coverage;

(v) Limited benefit health coverage, as defined under Maryland law;

(vi) An intensive care policy;

(vii) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a "to and from school" basis;

(viii) Benefits provided in long-term care insurance policies for non-medical services;

(ix) A Medicare supplement policy;

(x) A state plan under Medicaid;

(xi) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or

(xii) Personal injury protection benefits under a motor vehicle liability insurance policy.

(16) "Policyholder" means the primary insured or member named in a non-group insurance policy

(17) "Primary plan" means a plan whose benefits for an individual's health care coverage must be determined without taking the existence of any other plan into consideration.

(18) "Secondary plan" means a plan that is not a primary plan.

(19) "Specified disease policy" means a health insurance policy that:

(a) Is individually underwritten;

(b) Is guaranteed renewable;

(c) Provides benefits only for:

(i) A disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or

(ii) Additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases; and

(d) Does not provide benefits on an expense-incurred basis.

.03 Application of Definitions Used in Coordination of Benefits Provisions.

A. A carrier shall define the terms used in a coordination of benefits provision in a manner that is consistent with the definitions found in Regulation .02 of this chapter.

B. Allowable Expense Definition in Contract.

(1) A carrier shall specify in its allowable expense definition that:

(a) Except as provided in §B(1)(b) of this regulation, if an individual is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

(b) If the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(2) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug, or hearing aids.

(3) A plan that limits the application of COB to certain coverages or benefits may limit the definition of "allowable expense" in its contract to expenses that are similar to the expenses that it covers.

(4) When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" shall include similar expenses to which COB applies.

(5) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(6) The amount of the reduction may be excluded from allowable expense when a covered individual's benefits are reduced under a primary plan because the covered individual:

(a) Does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

(b) Has a lower benefit because the covered individual did not use a preferred provider.

C. Plan Definition in Contract.

(1) If separate parts of a plan for members of a group are provided through alternative contracts that are intended to be part of a coordinated package of benefits, the definition of plan shall indicate that:

(a) The separate parts of the plan shall be considered one plan; and

(b) There is no coordination of benefits among the separate parts of the plan.

(2) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract.

(3) Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may not be broader than the definition of "plan" in this chapter.

(4) If the definition of "plan" in the contract includes Medicare or other governmental benefits, that part of the plan definition may be limited to the hospital, medical, and surgical benefits of the governmental program.

(5) The reference to long-term care insurance for non-medical services in the definition of "plan" includes:

(a) Personal care;

(b) Adult day care;

(c) Homemaker services;

(d) Assistance with activities of daily living;

(e) Respite care;

(f) Custodial care; and

(g) Contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

D. Primary Plan Definition in Contract.

(1) A definition of "plan" used in a carrier's contract shall indicate that a plan is primary if:

(a) The plan has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

(b) All plans that cover the individual use the order of benefit determination rules required by this chapter and, under those rules, the plan determines its benefits first.

.04 Use of Model COB Contract Provision.

A. The model text set forth in Regulation .11 of this chapter:

(1) Contains a model COB provision for use in carrier's contracts; and

(2) The use of this model COB provision is subject to the provisions of §§ B—D of this regulation, and to the provisions of Regulations .05 and .06 of this chapter.

B. Use of the Model COB Contract Provision.

(1) A carrier is not required to use the specific words and format of the COB Contract provision contained in Regulation .11 of this chapter.

(2) A carrier may make changes to the COB provision contained in Regulation .11 of this chapter to:

(a) Fit the language and style of the rest of the contract; or

(b) Reflect differences among plans that provide services, that pay benefits for expenses incurred, and that indemnify.

(3) Other than allowed in (2) above, a carrier may not make changes to the COB provision contained in Regulation .11 of this chapter.

C. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(1) Another plan exists and the covered individual did not enroll in that plan;

(2) An individual is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) An individual has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

D. A plan may not contain a provision that its benefits are "always excess" or "always secondary," except in accordance with the rules permitted by this chapter.

E. Closed Panel Plans.

(1) Generally, under the terms of a closed panel plan, benefits are not payable if the covered individual does not use the services of a closed panel provider, except as provided for in Regulation .01B(5)(b) of this chapter.

(2) Except as described in §E(3) and (4) of this regulation, coordination of benefits does not occur if a covered individual is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability.

(3) Coordination of benefits may occur during the plan year when the covered individual receives emergency services that would be covered by both closed panel plans.

(4) If coordination of benefits occurs as described in §E(3) of this regulation, the secondary plan shall use the provisions of Regulation .07 of this chapter to determine the amount it must pay for the benefit.

F. A plan may not use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage the covered individual may have that does not meet the definition of "plan" under Regulation .02B(15) or is inconsistent with Regulation .03C of this chapter.

.05 Rules for Coordination of Benefits

A. When an individual is covered by two or more plans, the rules for determining the order of benefit payments are set forth in §§ B—D of this regulation and Regulation .06 of this chapter.

B. Payment by Primary Plans and Secondary Plans.

(1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered individual uses a non-panel provider, except for under the following circumstances:

(a) If the closed panel plan is a HMO, the HMO will be the primary plan if it is determined the service received from the non-panel provider is a covered service in accordance with §19-701(d) of the Health – General Article. The non-panel provider will be reimbursed in accordance with §19-710.1 of the Health – General Article.

(b) If the closed panel plan is an EPO, the EPO will be the primary plan if it is determined the service received from the non-panel provider is a covered service in accordance with §§14-205.1(a)(1)-(3) of the Insurance Article.

(c) If the closed panel plan is a DPO, the DPO will be the primary plan if it is determined the service received from the non-panel provider is a covered emergency service or is the result of an authorized referral.

(3) Multiple Contracts Providing Coordinated Coverage.

(a) When multiple contracts providing coordinated coverage are treated as a single plan under this chapter, Regulations .05 and .06 of this chapter apply only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.

(b) If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this chapter.

(4) Rules When More Than One Secondary Plan Exists.

(a) If an individual is covered by more than one secondary plan, the order of benefit determination rules of this chapter decide the order in which secondary plans benefits are determined in relation to each other.

(b) Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which under this chapter, has its benefits determined before those of that secondary plan.

C. Plans Having Order of Benefit Determination Provisions Inconsistent With This Chapter.

(1) Except as provided in §C(2) of this regulation, a plan that does not contain order of benefit determination provisions that are consistent with this chapter is always the primary plan unless the provisions of both plans, regardless of the provisions of this subsection, state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

(3) Examples of the supplementary coverage described in §C(2) of this regulation include:

(a) Major medical coverages that are superimposed over base plan hospital and surgical benefits; and

(b) Insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

D. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this chapter, it is secondary to that other plan.

.06 Order of Benefit Determination.

A. A plan determines its order of benefits using the first of the rules listed in §§ B—G of this regulation that applies.

B. Non-Dependent or Dependent.

(1) Subject to §B(2) of this regulation, the plan that covers the individual other than as a dependent, such as an employee, member, subscriber, policyholder, or retiree, is the primary plan and the plan that covers the individual as a dependent is the secondary plan.

(2) If the individual is a Medicare beneficiary, the order of the benefits is reversed from the rule described in §B(1) of this regulation so that the plan covering the individual as an employee, member subscriber, policyholder or retiree is the secondary plan and the other plan covering the individual as a dependent is the primary plan if, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the individual as a dependent; and

(b) Primary to the plan covering the individual as other than a dependent, such as a retired employee.

C. Dependent Child Covered Under More Than One Plan.

(1) Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as described in §C(2)—(4) of this regulation.

(2) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(a) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(b) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(3) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary;

(b) If the parent the court decree states is responsible for the dependent child's health care expenses or health care coverage has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan, except that this §C(3)(b) of this regulation shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(c) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of §C(2) of this regulation shall determine the order of benefits;

(d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of §C(2) of this regulation shall determine the order of benefits; or

(e) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefit for the child shall be as follows:

(i) The plan covering the custodial parent;

(ii) The plan covering the custodial parent's spouse;

(iii) The plan covering the non-custodial parent; and

(iv) The plan covering the non-custodial parent's spouse.

(4) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under §C(2) or (3) of this regulation as if those individuals were parents of the child.

(5) For a dependent child who has coverage under either or both of their parents' plans and also has their own coverage as a dependent under a spouse's plan, the order of benefits shall be determined in accordance with §F of this regulation.

(6) In the event the dependent child's coverage under their spouse's plan began on the same date as the dependent child's coverage under either or both of their parents' plans, the other of benefits shall be determined by applying the provisions of §C(2) of this regulation to the dependent child's parent(s) and the dependent child's spouse.

D. Active Employee or Retired or Laid-Off Employee.

(1) The plan that covers an individual as an active employee or the dependent of an active employee is the primary plan.

(2) The plan covering the same individual described in §D(1) of this regulation as a retired or laid-off employee or as a dependent of a retired or laid-off individual is the secondary plan.

(3) If the other plan does not have the rules described in §D(1) and (2) of this regulation, and as a result, the plans do not agree on the order of benefits, the rules described in §D(1) and (2) of this regulation are ignored.

(4) The rules described in §D(1) and (2) of this regulation do not apply if the rule in §B of this regulation can determine the order of benefits.

E. COBRA or State Continuation Coverage.

(1) If an individual whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the individual as an employee, member, subscriber, or retiree, or as the dependent of an employee, member, subscriber, or retiree is the primary plan, and the plan covering that same individual pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(2) If the other plan does not have the rule described in §E(1) of this regulation, and if, as a result, the plans do not agree on the order of benefits, the rule described in §E(1) of this regulation is ignored.

(3) The rule described in §E(1) of this regulation does not apply if the rule described in §B of this regulation can determine the order of benefits.

F. Longer or Shorter Length of Coverage.

(1) If the rules set forth in §§B—E of this regulation do not determine the order of benefits:

(a) The plan that covered the individual for the longer period of time is the primary plan; and

(b) The plan that covered the individual for the shorter period of time is the secondary plan.

(2) To determine the length of time an individual has been covered under a plan, two successive plans shall be treated as one if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended.

(3) The start of a new plan does not include:

(a) A change in the amount or scope of a plan's benefits;

(b) A change in the entity that pays, provides, or administers the plan's benefits; or

(c) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(4) The individual's length of time covered under a plan is measured from the individual's first date of coverage under that plan.

(5) If the individual's first date of coverage under a plan is not readily available for a group plan, the date the individual first became a member of the group shall be used as the date from which to determine the length of time the individual's coverage under the present plan has been in force.

G. If none of the rules described in §§ B—F of this regulation determines the order of benefits, the allowable expenses shall be shared equally between the plans.

.07 Procedure to Calculate Benefits and Pay a Claim for Secondary Plans.

A. In determining the amount to be paid on a claim by the secondary plan, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan.

B. The secondary plan may reduce its payment as calculated under §A of this regulation by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim.

C. In addition to paying benefits as described in §§A—B of this regulation, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

.08 Notice to Covered Individuals.

A plan shall, in its explanation of benefits provided to covered individuals, include the following language, "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

.09 Miscellaneous Provisions.

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this §A of this regulation shall be interpreted to require a plan to reimburse a covered individual in cash for the value of services provided by a plan that provides benefits in the form of services.

B. Rules When Non-Complying Plan is Involved.

(1) A plan with order of benefit determination rules that comply with this chapter ("complying plan") may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this chapter ("non-complying plan") on the following basis:

(a) If the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability.

(c) If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after the non-complying plan is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within 2 years of payment, the

complying plan receives information as to the actual benefits of the non-complying plan, the complying plan shall adjust payments accordingly.

(2) If the non-complying plan reduces its benefits so that the covered individual receives less in benefits than the covered individual would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation as described in §B(3) of this regulation, then the complying plan shall advance to the covered individual or on behalf of the covered individual an amount equal to the difference.

(3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered individual against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

C. COB Provisions and Subrogation Provisions.

(1) A COB provision differs from a subrogation provision.

(2) Provisions for COB or for subrogation may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

.10 Effective Date for Existing Contracts.

A. A contract that provides health care benefits and that was issued before the effective date of this chapter shall be brought into compliance with this chapter by:

(1) The later of:

(a) The first anniversary date or renewal date of the contract that occurs after the effective date of this chapter; or

(b) Twelve months following the effective date of this chapter; or

(2) The expiration of any applicable collectively bargained contract pursuant to which the contract of health care benefits was written.

.11 Model COB Contract Provision.

The model coordination of benefits provision referenced in Regulation .04A of this chapter shall read as follows:

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

*The Coordination of Benefits (COB) provision applies when an individual has health care coverage under more than one **Plan**. **Plan** is defined below.*

*The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.*

DEFINITIONS

*A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.*

*(1) **Plan** includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.*

*(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; a specified disease policy; specified accident coverage; limited benefit health coverage, as defined under Maryland law; an intensive care policy; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; coverage under other federal governmental plans, unless permitted by law; or personal injury protection benefits under a motor vehicle liability insurance policy.*

*Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.*

*B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.*

*C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the individual has health care coverage under more than one **Plan**.*

*When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.*

*D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the individual. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the individual is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered individual is not an **Allowable expense**.*

The following are examples of expenses that are not Allowable expenses:

*(1) The difference between the cost of a semi private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.*

*(2) If an individual is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.*

*(3) If an individual is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.*

*(4) If an individual is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement, and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.*

*(5) The amount of any benefit reduction by the **Primary plan** because a covered individual has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.*

*E. **Closed panel plan** is a **Plan** that provides health care benefits to covered individuals primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.*

*F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.*

*G. **Intensive care policy** is a health insurance policy that (1) is individually underwritten, (2) is guaranteed renewable, (3) provides benefits only for treatment received in the specifically designated facility of a hospital that provides the highest level of care and is restricted to patients who are physically and critically ill or injured, and (4) does not provide benefits on an expense-incurred basis.*

*H. **Specified disease policy** is a health insurance policy that (1) is individually underwritten; (2) is guaranteed renewable; (3) provides benefits only for (a) a disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or (b) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases; and (4) does not provide benefits on an expense-incurred basis.*

ORDER OF BENEFIT DETERMINATION RULES

*When an individual is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:*

*A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.*

*B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.*

*(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.*

*C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.*

*D. Each **Plan** determines its order of benefits using the first of the following rules that apply:*

*(1) Non-Dependent or Dependent. The **Plan** that covers the individual other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the individual as a dependent is the **Secondary plan**. However, if the individual is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the individual as a dependent; and primary to the **Plan** covering the individual as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the individual as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.*

*(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:*

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

*• The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or*

*• If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.*

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

*(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;*

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

** The **Plan** covering the **Custodial parent**;*

** The **Plan** covering the spouse of the **Custodial parent**;*

** The **Plan** covering the **non-custodial parent**; and then*

** The **Plan** covering the spouse of the **non-custodial parent**.*

*(c) For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.*

(d) For a dependent child who has coverage under either or both of their parents' plans and also has their own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) below applies.

(e) In the event the dependent child's coverage under their spouse's plan began on the same date as the dependent child's coverage under either or both of their parents' plans, the other of benefits shall be determined by applying the birthday rule in Subparagraph (a) above to the dependent child's parent(s) and the dependent child's spouse.

*(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers an individual as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same individual as a retired or laid-off employee is the **Secondary plan**. The same would hold true if an individual is a dependent of an active employee and that same individual is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.*

*(4) COBRA or State Continuation Coverage. If an individual whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the individual as an employee, member, subscriber, or retiree or covering the individual as a dependent of an employee, member, subscriber, or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.*

*(5) (a) Longer or Shorter Length of Coverage. The **Plan** that covered the individual as an employee, member, policyholder, subscriber, or retiree longer is the **Primary plan** and the **Plan** that covered the individual the shorter period of time is the **Secondary plan**.*

(b) To determine the length of time an individual has been covered under a plan, two successive plans shall be treated as one if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides, or administers the plans' benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan

(d) The individual's length of time covered under a plan is measured from the individual's first date of coverage under that plan. If that date is not readily available for a group plan, the date the individual first became a member of the group shall be used as the date from which to determine the length of time the individual's coverage under the present plan has been in force.

*(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.*

EFFECT ON THE BENEFITS OF THIS PLAN

*A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.*

*B. If a covered individual is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.*

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

*Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Insert name of carrier] may get the facts it needs from or give them to other organizations or individuals for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the individual claiming benefits. [Insert name of carrier] need not tell, or get the consent of, any individual to do this. Each individual claiming benefits under **This plan** must give [insert name of carrier] any facts it needs to apply those rules and determine benefits payable.*

FACILITY OF PAYMENT

*A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [insert name of carrier] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Insert name of carrier] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.*

RIGHT OF RECOVERY

*If the amount of the payments made by [insert name of carrier] is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the individuals it has paid or for whom it has paid; or any other individual or organization that may be responsible for the benefits or services provided for the covered individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.*